625 West Citracado Parkway, Suite 112
Escondido, CA 92025
Phone: 760 466-1520
Fax: 760 466-1525

RESEARCH REFERRAL FORM

Referring Provider Name/ Clinic: _____Referral Date: _____

Address:_____ City: _____

ZIP: _____ Phone:_____ Fax: _____

□ **Patient provided verbal consent to provide their information**

Patient Name: _____Date of Birth: _____

Home Phone: _____ Cell Phone/Other: _____

Best time to reach: _____AM _____PM

May we leave a message at these numbers? □ Yes □ No

Diabetes Type: □ 1 □ 2 Year of Diagnosis: _____

Most recent A1c: _____% Date of A1c: _____

Current diabetes medications: □ Orals □ Insulin □Both

□ I agree to share my information with AMCR Institute, Inc.

Signed: _____ Date: _____

Please fax completed form to (760) 466-1525 with a copy of the patient's medical history, physical and medication list. AMCR Institute will call and screen the patient within three business days and return the screen results to you.

FOR AMCR INSTITUTE USE ONLY:
Patient: □ is eligible Name of Study: _____ Screen Date: _____
Patient: □ is not eligible due to the following reasons: □ A1c □Age □ Type of Diabetes □ BMI □ Medication regimen □ Other:_____